| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 04/02/2014 |

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| BERKSHIRE OF CASTLETON | 8480 CRAIG ST<br>INDIANAPOLIS, IN 46250 |

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| R000000 | | R000000 | | |
| | This visit was for a State Residential Licensure Survey<br><br>Survey dates : March 31, April 1 & 2, 2014<br><br>Facility number :009894<br>Provider number : 009894<br>AIM number : N/A<br>Survey Team: Michelle Hosteter, RN<br>Census bed type:<br>Residential : 124<br><br>Census payor type:<br>Other: 124<br><br>Sample : 7<br><br>These state findings are cited in accordance with 410 IAC 16.2.<br><br>Quality Review completed on April 10, 2014, by Brenda Meredith, R.N. | | | |
| R000092 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - Noncompliance<br>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:<br>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.<br>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.<br><br>Based on interview and record review, the facility failed to have fire drills with the local fire department every 6 months.<br><br>Findings include:<br><br>The fire drills for 2013 were reviewed on 3/31/14 at 1:00 P.M. There was no documentation of a fire drill attempted or performed with the local fire department in the fire drill book provided.<br><br>In an interview with the Executive Director, on 4/1/14 at 2:00 P.M., she indicated she thought the drills with the fire department only had to be done yearly. She indicated the facility only had one drill with the fire department in 2013. | R000092 | No Residents residing in the community were affected by this deficient practice. No other residents were affected by deficient practice. The facility will attempt to hold a fire and disaster drill in conjunction with the local fire department at least every six months. Past fire and disaster drills documentation will be reviewed for compliance and a record of all training and drills will be documented.The maintanence director/designee will conduct and document fire and disaster drills in accordance with the state regulation and Brookdale Livings policy and procedure.The executive director/designee will monitor fire and disaster drill quarterly times 2 and review results with safety committee, to ensure the deficient practice will not recur. Systemic changes will be completed by 4/16/2014 | 04/30/2014 |
| R000216 | 410 IAC 16.2-5-2(c)(1-4)(d)<br>Evaluation - Noncompliance<br>(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of | | | |

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| | the following:<br>(1) The resident ' s physical, cognitive, and mental status.<br>(2) The resident ' s independence in the activities of daily living.<br>(3) The resident ' s weight taken on admission and semiannually thereafter.<br>(4) If applicable, the resident ' s ability to self-administer medications.<br>(d) The evaluation shall be documented in writing and kept in the facility.<br><br>Based on interview and record review, the facility failed to weigh residents semiannually for 2 of 5 residents reviewed for weights. (Resident #1 and #67) The facility also failed to complete self medication evaluations for residents administering their own medications. This affected 2 of 5 residents reviewed for evaluations in a sample of 7. (Residents #104, #67)<br><br>Findings include:<br><br>1. On 3/31/14 at 11 A.M. the record review for Resident #67 was completed. Diagnoses included, but were not limited to, coronary artery disease, diabetes and high cholesterol.<br><br>The physician's orders for March 2014 indicated the resident was able to self medicate.<br><br>The weight book was reviewed and the weights for 2013 reviewed. The only weight documented for Resident #67 was from 1/28/13.<br><br>There was no documentation found on self medication assessment. | R000216 | Residents #1 was weighted immediately and place on records to be weighted in semiannually. Orders were obtained from MD to identify medications that are self administered. Resident #67 was weighted immediately and planced on records to be weighted in semiannually.Orders were obtained from MD to identify medications that are self administered.The facilty identified other residents having the potential to be affected by the same deficient practice by auditing weight records and medication administration record of the residents who reside in the community. No other residents were identified.Semiannually the residents that reside in the community will receive a re-weight and re-self administration evaluation along with the scheduled re-assessment semiannually. Records will be review weekly x4 weeks. The corrective actions will be monitored by the healthwellness director/designee to ensure the deficient practice | 04/30/2014 |

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| | On 3/31/14 at 3:00 P.M., the Director of Nursing (DoN) indicated she could not locate any other weights from 2013 or a self medication assessment for Resident #67 who was able to self medicate. There was no documentation which indicated the resident had been assessed to self medicate.<br><br>2. On 3/31/14 at 10:00 A.M., the record review for Resident #1 was completed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and mild dementia.<br><br>The physician's orders indicated on 8/7/13 there was an order that indicated , "...Iprat-Albut 0.5-3(2.5) milligrams/3 milliliters (ml) inhale 3 ml 4 times a day (resident self administers)...."<br><br>The nurses notes indicated on 12/2/13, "...Resident had been self administering nebulizer...."<br><br>There was no documentation found for a self medication assessment for Resident #1.<br><br>3. On 3/31/14 at 2:00 P.M., the record review for Resident #104 was completed. Diagnoses included, but were not limited to, diabetes, coronary artery disease, and congestive heart failure.<br><br>The weight book documentation indicated resident #104 did not have weights recorded.<br><br>On 3/31/14 at 3:00 P.M., the Director of Nursing (DoN) indicated she could not locate any weights from 2013 for Resident # 104.<br><br>During an interview on 3/31/14 at 3:00 P.M., the Director of Nursing (DoN) indicated she | | will not recur.Completed by 4/30/2014 | |

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| | could not locate a self medication assessment for Resident #1 or 2013 weights for Resident #104. | | | |
| R000217 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and<br>(D) preference;<br>of the resident.<br>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.<br>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.<br>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.<br>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.<br><br>Based on interview and record review, the facility failed to include all medication information for a resident on the service plan for 1 of 5 reviewed for service plans in a sample of 7. (Resident #1) | R000217 | Resident #1 service plan was updated. An audit of the patient service plan will be completed to identify other residents affected by the deficient practice. No other residents were identified as being affected by the same | |

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| | Findings include:<br><br>On 3/31/14 at 10:00 A.M., the record review for Resident #1 was completed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and mild dementia.<br><br>The physician's orders indicated on 8/7/13 there was an order that indicated , "...Iprat-Albut 0.5-3(2.5) milligrams/3 milliliters (ml) inhale 3 ml 4 times a day (resident self administers)...."<br><br>The nurses notes indicated on 12/2/13, "...Resident had been self administering nebulizer...."<br><br>On 3/31/14 at 3:10 P.M., the Director of Nursing (DoN) indicated there was no indication for the self medicating of nebulizer treatments on the service plan dated 2/7/14 for Resident #1. | | deficient practice. A evaluation of the residents needs will be completed prior to admission into the community, every six months, with change of conditions and as needed. The deficient practice will be monitored by the healthwellness director/designee. Evaluations will be audited weekly x4, monthly X 1 and quarterly thereafter. Completed by 4/30/2014 | |
| R000298 | 410 IAC 16.2-5-6(c)(2)<br>Pharmaceutical Services - Deficiency<br>(2) A consultant pharmacist shall be employed, or under contract, and shall:<br>(A) be responsible for the duties as specified in 856 IAC 1-7;<br>(B) review the drug handling and storage practices in the facility;<br>(C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping;<br>(D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and<br>(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. | | | |

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| | Based on interview and record review the facility failed to ensure the pharmacy was performing drug regimen reviews on all residents every 60 days for 2 of 5 residents reviewed for pharmacy recommendations in a sample of 7. (Residents # 119 and #4)<br><br>Findings include:<br><br>1. On 4/1/14 at 12:30 P.M. the record review for Resident #4 was completed. Diagnoses included, but were not limited to, Stage III renal failure, diabetes, myasthenia gravis, dementia, and graves disease. The resident was admitted January 24, 2003.<br><br>On 3/31/14 the Director of Nursing (DoN) provided a Pharmacy book which she indicated should have all of the medication regimen reviews done for all of the residents for 2013 to current date. She indicated those residents who were self medicating may not have a review done on them since they are independent with their medications.<br><br>The pharmacy review dates for Resident #4 were as follows: 3/4/14, 1/8/14, and 7/3/13.<br><br>2. On 4/1/14 at 10:30 A.M. the record review for Resident #119 was completed. Diagnoses included, but were not limited to, diabetes, congestive heart failure and stroke. The resident was admitted 1/10/14.<br><br>There was no documentation found for a drug regimen review for Resident #119.<br><br>On 4/1/14 at 3:00 P.M., the DoN indicated she did not know why the reviews were not completed as they should be. | R000298 | A drug regiment was completed for resident #119. A drug regiment was completed for resident #4. A audit of the pharmacy evaluations was completed to identify other residents that have been affected by the deficient practice. No other residents were affected. A patient roster will be used to identify residents receiving a drug regimen by pharmacy. The corrective actions will be monitored by healthwellness director/designee. On monthly pharmacy visits, the HWD/designee will compare reviewed residents to resident roster to ensure all residents receiving medication administration are reviewed every 60 days. This will be completed monthly.Completed by 4/30/2014 | 04/30/2014 |

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| R000354 | On 4/1/14, the Executive Administrator provided an undated document titled, "Pharmacy Products and Services Agreement" indicated, "...6.1 Compliance with Healthcare Laws...will comply in all material respects with all applicable statues, regulations rules, orders, ordinances...."<br>410 IAC 16.2-5-8.1(g)(1-7)<br>Clinical Records - Noncompliance<br>(g) A transfer form shall include the following:<br>(1) Identification data.<br>(2) Name of the transferring institution.<br>(3) Name of the receiving institution and date of transfer.<br>(4) Resident ' s personal property when transferred to an acute care facility.<br>(5) Nurses ' notes relating to the resident ' s:<br>(A) functional abilities and physical limitations;<br>(B) nursing care;<br>(C) medications;<br>(D) treatment; and<br>(E) current diet and condition on transfer.<br>(6) Diagnosis.<br>(7) Date of chest x-ray and skin test for tuberculosis.<br><br>Based on interview and record review, the facility failed to have all of the transfer information completed prior to sending a resident to the hospital for 1 of 2 closed records reviewed in a sample of 7. (Resident #126)<br><br>Findings include:<br><br>1. On 4/1/14 at 10:40 A.M. the record review for Resident #126 was completed. | R000354 | Resident #126 no longer resides at community. No other resident was affected by this deficient practice. An inservice will be completed to train staff on the proper documentation of the emergency paperwork. Deficient practice will be monitored by healthwellness director/designee weekly X 4, monthly X 1 and quarterly thereafter. completed by 5/16/2014 | 05/16/2014 |

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| | Diagnoses included, but were not limited to, irritable bowel syndrome, diastolic heart dysfunction, and diverticular bleeding.<br><br>The nurses notes indicated the resident was sent to the hospital on 10/15/13 due to her "pacemaker sparking and resident short of breath." The document titled "Notice of Transfer or Discharge" only had the name and address of the facility and the local ombudsmen's name information provided, the rest of the document was blank.<br><br>The resident transfer discharge document dated 10/15/13, had the name of the resident and date of birth, hospital it was transferring to, the physician name and phone number, the facility address and phone number and diagnosis at time of transfer being "defibilator(sic) sparked." There were no vital signs or indication of the resident being short of breath.<br><br>In an interview on 4/1/14 at 11:20 A.M. the Director of Nursing indicated that Resident # 126 was very independent and that this was the reason there was no transfer documentation filled out. | | | |
| R000355 | 410 IAC 16.2-5-8.1(h)<br>Clinical Records - Nonconformance<br>(h) Current clinical records shall be completed promptly, and those of discharged residents shall be completed within seventy (70) days of the discharge date.<br><br>Based on interview and record review, the facility failed to have all of the clinical record information completed within 70 days of discharge for 1 of 2 closed records reviewed in a sample of 7. (Resident #126) | R000355 | Resident #126 no longer resides at community. No other resident was affected by this deficient practice. An inservice will be completed to train staff on the proper documentation of the emergency paperwork. Deficient | |

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| | Findings include:<br><br>1. On 4/1/14 at 10:40 A.M. the record review for Resident #126 was completed. Diagnoses included, but were not limited to, irritable bowel syndrome, diastolic heart dysfunction and diverticular bleeding.<br><br>The nurses notes indicated the resident was sent to the hospital on 10/15/13 due to her "pacemaker sparking and resident short of breath." The document titled "Notice of Transfer or Discharge" only had the name and address of the facility and the local ombudsmen's name information provided, the rest of the document was blank.<br><br>The resident discharge summary indicated the resident moved out on 11/12/13.<br><br>There was no "Notice of Transfer or Discharge" documentation completed. The nurses notes had no indication of the reason for discharge and where the resident went.<br><br>On 4/1/14 at 11:20 A.M., the Director of Nursing indicated that Resident # 126 was very independent and that this was the reason there was no transfer documentation filled out. | | practice will be monitored by healthwellness director/designee weekly X 4, monthly X 1 and quarterly thereafter. completed by 5/16/2014 | |
| R000410 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.<br>(f) For residents who have not had a documented negative tuberculin skin test | | | |

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| | result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br><br>Based on interview and record review, the facility failed to complete tuberculin (TB) skin tests at admission and annually for 2 of 5 residents reviewed in a sample of 7. (Residents #119, #67, #1)<br><br>Findings include:<br><br>1. On 4/1/14 at 10:30 A.M. the record review for Resident #119 was completed. Diagnoses included, but were not limited to, diabetes, congestive heart failure and stroke. The resident was admitted 1/11/14 at 5:00 P.M.<br><br>The MAR (Medication Administration Record) for January 2014 indicated the resident received a 1st step PPD (Purified Protein Derivative) on 1/13/14.<br><br>This was 2 days after admission.<br><br>2. On 3/31/14 at 11 A.M. the record review for Resident #67 was completed. Diagnoses included, but were not limited to, coronary artery disease, diabetes and high cholesterol. | R000410 | Resident #67 received his tuberculin skin test was completed. Resident #119 received his/her tuberculin skin test was completed. A audit of residents residing in the community was completed. No other residents identified to be affected by deficient practice. Healthwellness director has updated a PPD tracking system system to identify residents due for annual tuberculin skin test. Healthwellness director will monitor completion of testing weekly X 4, monthly X 1 and quarterly thereafter. Completed by 4/30/2014 | 04/30/2014 |

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| | The tuberculin testing documentation for Resident #67 indicated the last PPD test performed was on 10/16/12.<br><br>3. On 3/31/14 at 10:00 A.M., the record review for Resident #1 was completed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and mild dementia.<br><br>The tuberculin testing documentation for Resident #1 indicated the last PPD test performed was on 2/1/13.<br><br>There was no documentation the resident had a PPD in 2014.<br><br>On 4/1/14 at 9:05 A.M., the Director of Nursing indicated she had no explanation as to why the TB tests were not completed in a timely fashion. | | | |